

Leave Buy Back (LBB) Worksheet/
Certification and Election

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs



Employee Statement — Please carefully read instructions on pages 3 and 4 *before* filling out this form.

A. Name of Employee: (Last, First, Middle)

B. OWCP File Number:

C. Social Security Number:

D. Period for Which Compensation is Claimed to Repurchase Leave

From: ____ / ____ / ____ To: ____ / ____ / ____

I. Agency Estimate of FECA Entitlement:

A. Weekly Base Payrate (excluding overtime)

- Date of Injury ____ / ____ / ____ \$ _____
- Date Stopped Work ____ / ____ / ____ \$ _____
- Date of Recurrence ____ / ____ / ____ \$ _____

Enter the greatest amount and the effective date of that amount on line 1.

1. _____
____ / ____ / ____
(effective date)

B. Additions to Base Pay:

If employee works a regular schedule, state the amount earned weekly. If irregular schedule, state amount earned 1 year prior to date entered on line 1 ÷ by 52.

- Night Differential 2. _____
- Sunday Premium 3. _____
- Subsistence/Quarters 4. _____
- Other (Specify) 5. _____

C. Total Weekly Payrate (Add lines 1 through 5)

6. _____

D. Compensation Rate (Circle either 2/3 or 3/4)

7. 2/3 3/4

E. Total Hours Claimed on CA-7a

8. _____

F. Total Hours Worked per Week

9. _____

G. Formula (for FECA Entitlement)

$$\begin{array}{c} \$ \\ \text{(Weekly Payrate} \\ \text{See Line 6)} \end{array} \times \begin{array}{c} \\ \text{(Compensation Rate} \\ \text{See Line 7)} \end{array} \times \begin{array}{c} \text{(Hours} \\ \text{See Line 8)} \end{array} + \begin{array}{c} \text{(Hours Wkd/Wk} \\ \text{See Line 9)} \end{array} = 10. \$ \end{array}$$

II. Agency Certification:

H. Total Amount Due Agency to Repurchase Leave

11. \$ _____

I. Estimate of FECA Entitlement (See Line 10)

12. \$ _____

J. Balance Due Agency from Employee (Line H minus Line I)

13. \$ _____

I hereby certify that the above is consistent with agency payroll records.

The employing agency agrees to allow the employee to repurchase his/her leave. Leave records will be, or have been, changed from "Leave with Pay" to "Leave without Pay" for the period shown on the leave analysis.

I further certify that if this claim is signed by the employee, the employee has made arrangements to pay the agency the balance between the total amount the agency requires to recredit leave and the amount of the FECA entitlement.

(Signature of Agency Official)

(Title/Position)

Phone No: _____

Date Signed: _____

Employing Agency Address for Check: _____

III. Employee Claim:

_____ **K.** I hereby elect *not* to repurchase the leave used at this time.

_____ **L.** I hereby elect FECA compensation to repurchase leave used for medical care or disability resulting from my job-related injury or condition.

I understand that I am responsible for paying my agency the difference between the FECA entitlement and the amount my agency requires to restore my leave, and have done or made arrangements for this.

I understand that if my actual entitlement to FECA compensation is within 10% of the amount estimated above, OWCP will process the leave buy back. If the payrate used in the worksheet above is within 10% of the payrate determined by FECA, and less than the full period claimed is approved, OWCP will process payment for the approved period.

(Signature of Claimant)

(Date Signed)